**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Children and Family Services
CFS-2146 (Rev. 11/2003)

# SERIOUS INCIDENT REPORT

**Use of this form:** Use of this form is voluntary. Any incident meeting the requirements of BRL CW memo 99-06 should be reported on this form. If this form is not used, all information requested on this form must be provided. Filling out this form will assist in meeting the requirements of s. 48.66(3), Wis. Stats., and HFS 52.11(12) and (14), 54.06(3), 57.01(1), 57.08(4), 59.01(1) and 59.07(4). Personally identifiable information on this form will be used only to determine compliance with HFS 57, HFS 54, HFS 52 and Chapter 48, Wis. Stats., and to assist in investigations concerning serious incidents in licensed residential facilities.

**Instructions:** If more space is needed to complete the report, attach a separate page. **If restraints were utilized, page 3 must be completed.** Mail or fax completed report to your state licensing specialist.

| Date - Report Completed | Name - Person Completing Form | Telephone Number |
|---|---|---|
| Date - Incident Occurred | Name - Agency / Facility | |
| Time - Incident Began | Location Incident Occurred (Include address: Street, City, State) | |
| Time - Incident Ended | | |

Describe incident and circumstances leading up to it. Include specific time, place, staff involved, resident(s) involved and what de-escalation techniques were used.

**Youth Involved**

| Name | Birthdate (mm/dd/yyyy) | Placing Agency |
|---|---|---|
| Name | Birthdate (mm/dd/yyyy) | Placing Agency |
| Name | Birthdate (mm/dd/yyyy) | Placing Agency |

**Staff Person(s) / Foster Parent(s) Involved in Incident**

| Name | Telephone Number | Name | Telephone Number |
|---|---|---|---|
| Name | Telephone Number | Name | Telephone Number |

**Other Agencies Involved in Incident (Medical, law enforcement, placing agency, school, etc.)**

| Name | Address (Street, City, Zip Code) |
|---|---|
| Name | Address (Street, City, Zip Code) |
| Name | Address (Street, City, Zip Code) |

## Facility Follow-Up Action

Agency / facility immediate follow-up with children involved, including debriefing and medical care and / or any resulting changes in the client's treatment plan - Describe.

Agency / facility follow-up with staff / foster parent(s) involved - Describe.

Specific measure(s) the agency / facility will take to prevent further similar incidents from occurring - Describe.

**SIGNATURE** - Person Completing Form | Title - Person Completing Form | Date Signed (mm/dd/yyyy)

**SIGNATURE** - Supervisor | Title - Supervisor | Date Signed (mm/dd/yyyy)

**To Be Completed by Licensing Specialist**

☐ Yes ☐ No Further action needed

If "Yes" what action was taken?

If "No" explain:

**SIGNATURE** - Licensing Specialist | Date Signed (mm/dd/yyyy)

## SUBMIT THIS PAGE ONLY IF RESTRAINTS WERE UTILIZED

Describe the precipitating event, including the imminent danger to self or others; any de-escalation interventions attempted and reasons they were not successful.

Describe the type of restraint, the verbal / physical behavior of the client during the restraint and the length of time the restraint was used.

Describe the reason the restraint was ended and any injuries that occurred and medical care received.

Provide the names of staff involved in the restraint and a description of any crisis intervention training each staff has received, including dates of completion.